

The Coast to Coast Hauora Trust - Heritage Rest Home

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: The Coast to Coast Hauora Trust

Premises audited: Heritage Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 26 January 2021 End date: 26 January 2021

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 14

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Heritage Rest Home provides rest home level care for up to 17 residents. The service is operated by the Coast to Coast Hauora Trust. An experienced nurse manager manages the day to day activities of the facility. Residents and families spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Service Standards. The audit process included review of policies and procedures, review of residents' and staff files, observations, and interviews with residents, family/whānau, management and staff.

Areas requiring improvement from the previous audit relating to the complaints register, transcribing of medicines and reporting of infections to the surveillance programme have been addressed.

Areas requiring improvement from this audit relate to the repair and maintenance of the building and the kitchen.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Effective communication to residents and their family/whānau/friends occurs and interpreter service can be accessed as required.

A complaints register is maintained with complaints resolved promptly and effectively. There have been no complaint investigations by an external agency since the previous audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Coast to Coast Hauora Trust is the governing body and is responsible for the services provided. A business, quality and risk plans document a mission statement, philosophy, service scope risk management goals, objectives, and business risks. Systems are in place for monitoring the services provided.

The chief executive officer who is a registered nurse has overview of the service and a nurse manager is responsible for the day to day running of the facility. The nurse manager has returned to the position after leaving in 2020 and has been in the position for nine years overall. The nurse manager is supported by the chief executive officer.

Quality and risk management systems are in place. There is an internal audit programme. Adverse events are documented on accident/incident forms. Quality data is being collated, analysed and evidenced corrective action plans are developed and implemented. Staff and resident meetings are held.

There are policies and procedures on human resources management. Human resource processes are followed. An in-service education programme is provided, and staff performance is monitored. Care staff are encouraged to complete the New Zealand Qualifications Authority Unit Standards.

There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery that is based on best practice. The nurse manager is on call after hours.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family/whānau.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The building warrant of fitness is displayed at the main entrance to the facility. There have been no structural alterations since the previous audit.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There was a resident using a restraint at the time of audit.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	16	0	0	1	0	0
Criteria	0	41	0	0	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information is provided to residents and families on admission and there is complaints information and forms available at the main entrance. Residents and family/whānau stated that communication about anything they are concerned about is actioned immediately.</p> <p>Review of the register and documentation and interview of the NM evidenced three complaints have been received since the previous audit. The complaints were relating to the same staff member by three different complainants. The staff member has since left employment. Review of documentation evidenced complaints concerning the facility are managed well and the timeframes meet Right 10 of the Code. The requirement from the previous audit is closed.</p> <p>Staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There have been no complaint investigations undertaken by external agencies since the previous audit.</p>
Standard 1.1.9: Communication Service providers	FA	<p>Residents and family/whānau interviewed stated they are kept well informed about any changes to their/their relative's status and outcomes of regular and any urgent medical reviews. The resident/ family/whānau survey for 2020 confirmed this. This was also supported in the residents' files reviewed. Staff understood the principles of open disclosure, which is supported by policy and procedures that meet the requirements of the</p>

communicate effectively with consumers and provide an environment conducive to effective communication.		<p>Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>Interpreter services can be accessed if required, although the nurse manager (NM) stated this is rarely needed. Usually, family/whānau members or staff can be utilised.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Coast to Coast Hauora Trust (the Trust) is the governing body and is responsible for the services provided. A business plan 2021-2020 documents a mission statement, philosophy, service scope risk management goals, objectives, and business risks.</p> <p>The day-to-day management of the service is the responsibility of the nurse manager with the overall operations provided by the chief executive officer (CEO) who is also an RN. The nurse manager left employment on the 20 November 2020 and a new nurse manager started in the position on the 3 November 2020. The new nurse manager left employment two months later and the previous nurse manager has returned until a new nurse manager has been recruited and orientated to the role. The nurse manager reported the Trust is currently advertising for a new nurse manager. The nurse manager works three days per week and stated the appropriate person at the DHB has been advised of the changes concerning the nurse manager and was advised during the audit to notify HealthCERT.</p> <p>The CEO and NM meet formally two weekly and discuss all activities concerning Heritage Rest Home. Minutes of meetings and interview of the NM confirmed this.</p> <p>Meeting minutes for the annual general meeting include review of the goals in the business plan and a report by the nurse manager that includes but not limited to clinical indicators, survey results, complaints and maintenance of the building.</p> <p>The facility can provide accommodation for up to 17 residents. On the day of this audit there were 14 residents. Thirteen residents are under the age-related residential care contract and one resident is under an ACC contract. The service also holds a contract for respite care and primary options for acute care (POAC) contract with the DHB.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous</p>	FA	<p>The organisation has quality and risk management systems that guides the quality programme. Risk management activities are appropriate for the size and scope of the organisation. Quality data is collected, collated and analysed to identify any trends. Corrective action plans are developed in response to identified issues in a range of ways, including audits, incident/accident reports, complaints, surveys and deficits identified from meetings. Quality data is graphed month by month by the NM and is available for staff. Staff stated they discuss trends and corrective actions at the staff meetings and at handover. The NM demonstrated sound knowledge relating to quality and risk management.</p>

quality improvement principles.		<p>Satisfaction surveys for 2020 were reviewed and responses demonstrated a high level of satisfaction and were complementary of the care provided especially the food service. Resident meetings minutes evidenced these are held on a regular basis, apart from during the Covid-19 lock downs. Quality and risk management issues are reported and discussed at management level and at the staff meetings. Review of the meeting minutes and interview of staff confirmed this.</p> <p>Policies and procedures are fully imbedded and are relevant to the scope and complexity of the service, reflected current accepted good practice and reference legislative requirements. Policies and procedures are reviewed regularly and were current with a document review and amendment log kept. New / reviewed policies are available for staff to read and sign off once read. Staff confirmed the policies and procedures provided appropriate guidance for service delivery and they were advised of new policies/ revised policies. Obsolete documents are archived.</p> <p>A risk register forms part of the quality plan and includes risks concerning both organisational and the service.</p> <p>The health and safety policy covers all aspects of health and safety management. Actual and potential risks are identified and documented in the hazard/risk register. The register identifies hazards/risks and showed the actions put in place to minimise or eliminate risks. Newly found hazards/risks are communicated to staff. Hazards and safety issues are discussed at staff meetings. The NM demonstrated a sound knowledge of health and safety. Staff confirmed they understood and implemented documented hazard identification processes.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events on an incident/accident form. All forms are reviewed by the NM and the family/whānau contacted as appropriate. Incidents/accidents are investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated and analysed by the NM and trends shared with staff through staff meetings and handover. Graphs are generated and give good information for staff. A register is kept with outcomes and improvements documented.</p> <p>The NM stated there have been no essential notifications to external agencies since the last audit apart from the change to the NM position. The NM is aware of essential notification reporting requirements.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are</p>	FA	<p>Policies and procedures relating to human resources management are in place. Staff files include job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, police and visa vetting and training certificates.</p> <p>New staff are required to complete the induction programme. Staff are 'buddied' and supported by an</p>

<p>conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>experienced staff member with several competencies to complete. Staff performance is reviewed at the end of six weeks by the NM and yearly thereafter unless there are performance issues. Staff performance appraisals were current. Annual practising certificates were current for staff and contractors who required them to practice.</p> <p>The education programme is the responsibility of the NM. Records are held for staff attendance at training sessions. In-service education is provided for staff and there was documented evidenced that this was provided at least monthly. During the Covid-19 lock downs training was interrupted and has since resumed. The gerontology nurse specialist from the local DHB provides a variety of on-going training for staff throughout the year. All staff have current first aid certificates.</p> <p>Medication competencies for senior care givers responsible for medicine management were current and other caregivers have a current 'second checker' competency for controlled drugs.</p> <p>The Careerforce education programme is also available for staff to complete and staff are encouraged to do so. The team leader has level 4 and staff who have attained level 3 are currently completing level 4. One caregiver has level 2. An external person is the assessor for the facility.</p> <p>Staff confirmed they have completed an induction, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented rationale for determining staffing levels and skill mix to provide safe service delivery including acuity, skill mix of experienced staff and less experienced staff.</p> <p>The NM advised there is a pool of two casual staff if needed. The NM reported the rosters are adjusted to meet the changing needs of residents, resident acuity including occupancy and the environment.</p> <p>The NM works three days per week- Monday, Thursday and Friday and is interRAI trained. Review of the rosters evidenced the team leader and a caregiver are on the morning shift, a team leader and a caregiver are on the afternoon shift and one caregiver on at night. Caregivers are responsible for the cleaning and laundry. The activities coordinator works Thursdays 10am to 3pm and caregivers are responsible for activities as well. The NM is on call seven days a week with back up from the medical centre and the CEO.</p> <p>The kitchen has two cooks who provide the meal service seven days a week. The NM reported there is currently no maintenance person to attend to the general maintenance of the facility. Maintenance of the gardens and lawn mowing is contracted out.</p> <p>Residents, family/whānau and staff interviewed reported satisfaction with the staffing levels. Staff reported they can get through their work. Observations during the audit confirmed staffing levels are adequate.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Regular medication audits are completed and are followed with appropriate corrective actions. There are evidences of pharmacy involvement.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are not used.</p> <p>There are no residents who were self-administering medications at the time of audit. Staff interviewed understands appropriate processes to ensure this was managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by cook and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian and it is currently being reviewed.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Auckland Council effective from 28 August 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made</p>

		<p>known to kitchen staff and accommodated in the daily meal plan.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family/whānau interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The residents, staff and family/whānau interviewed, verified that medical input is sought in a timely manner, that medical orders are followed. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by an activities' coordinator. A range of activities are provided as per the weekly activities calendar. Regular resident outings and active involvement in activities happening in the community are part of planned activities,</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as part of the formal six monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings. Residents interviewed confirmed they enjoy the programme.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes and 24-hour care records. If any change is noted, it is communicated to Registered Nurse or Medical Practitioner as required.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, wound. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Moderate	<p>A building warrant of fitness is displayed at the entrance to the facility that expires of the 30 June 2021. There have been no structural alterations since the previous audit. The building internally and externally is not being maintained to an adequate standard and is in need of repairs, maintenance and painting. The kitchen is in need of modernising and the CEO reported there are plans to renovate it.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the Chief Executive Officer and to the board. All the infections reported were entered onto the monthly report. Facility maintains low infection rate.</p> <p>Covid-19 pandemic preparedness document is sighted and staff interviewed are aware of this plan.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that</p>	FA	<p>The restraint minimisation and safe practice policy includes a definition, assessment and evaluation details and complies with the requirements of the standard. There were no residents using an enabler and one resident using a restraint at the time of audit. The resident's file reviewed and interview of the NM evidenced</p>

the use of restraint is actively minimised.		appropriate documentation is in place. Staff interviewed demonstrated sound knowledge of the difference between a restraint and an enabler and the process should a resident request an enabler. Staff have received on-going education relating to challenging behaviours, enablers and restraint.
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Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA</p> <p>Moderate</p>	<p>Residents and families stated they can move freely around the facility and that the accommodation meets their needs. There is easy access to communal areas and observations during the audit confirmed this.</p> <p>The NM stated contractors are used for most maintenance, however, there is no person who undertakes general minor maintenance for the facility. The NM reported a builder is contracted, however, review of meeting minutes and interview of staff evidenced reporting of areas that need attention is reported month after month with little apparent action. A list of 20 issues was sighted including for example, the window in room 17 is coming out of the frame, laundry windows will not shut, issues with leaking spouting, putty around windows is missing allowing water in and several doors jam and cannot be shut. The auditor observed staff struggling to shut the door to the cupboard that holds the chemicals.</p> <p>The kitchen is worn with the vinyl flooring torn, the bench top has worn through the surface in places, the cupboard surfaces are worn and not made of impervious material, which has the potential for infection control issues. The CEO advised there are plans to renovate the kitchen and it is intended this will start in March 2021. However, this will depend on</p>	<p>The building both internally and externally is not being maintained to an adequate standard.</p>	<p>Provide evidence of (i) a plan and timeframes for the repair and maintenance of the building and evidence that the items listed on the 'maintenance sheet' are addressed, (ii) progress relating to the renovation of the kitchen and if funding is not secured, evidence that the areas in need of repair and maintenance are addressed.</p> <p>90 days</p>

		<p>securing funding.</p> <p>The building externally is in need of repair and maintenance. Most of the building has paint peeling off and, in some areas, this is down to the bare timber with areas of dry rot evident.</p>		
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Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.